

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4937AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2008
NAME OF PROVIDER OR SUPPLIER AS TIME GOES BY 7		STREET ADDRESS, CITY, STATE, ZIP CODE 4240 AL CARRISON LAS VEGAS, NV 89129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted in your facility on 12/5/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 10 Residential Facility for Group beds for persons with Alzheimer's disease, Category II.</p> <p>The census at the time of the survey was 8.</p> <p>Eight resident files were reviewed and 6 employee files were reviewed.</p> <p>There were no complaints.</p> <p>There were no deficiencies identified at the time of the survey.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p>	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE